Puget Sound Region

Pre-Hospital Emergency Triage and Treatment Annex

Regional Catastrophic Disaster Coordination Plan

March 28, 2011

Puget Sound Regional Catastrophic Preparedness Program
PRE-HOSPITAL EMERGENCY TRIAGE AND TREATMENT ANNEX

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I. OVERVIEW AND ASSUMPTIONS

A. Purpose

This annex to the *Puget Sound Regional Catastrophic Disaster Coordination Plan* provides a strategic framework for regional coordination to plan for or respond to any naturally occurring or man-made catastrophe. Such incidents may produce medical surge demands that stress or overwhelm Emergency Medical Services (EMS), Public Health, and health care organizations in the Puget Sound Region and require a regionally coordinated response to promote continuity of patient care from the field to the hospital or other definitive care site. This annex provides the necessary coordination structure and processes, currently lacking in the Puget Sound Region, to facilitate a multi-jurisdictional, multi-disciplinary pre-hospital response to a catastrophe.

The coordination processes described in this annex **do not** usurp or infringe upon the formal chain of command during incident response. These processes also do not impede or replace established mechanisms for incident management support, which flow from local jurisdictions to their respective county Emergency Management Agency and then to the Washington Military Department, Emergency Management Division. Rather, this annex provides a mechanism for pre-hospital responders to collect and share information in order to develop regional situational awareness and recommendations on strategic or policy-level issues affecting the pre-hospital response. These recommendations are intended to help decision makers better understand the region's pre-hospital needs so that they can make informed decisions in support of the region's planning for and response to catastrophic incidents (see section IV).

B. Scope

This annex applies to EMS providers, Public Health, health care organizations, and any other entities that are responsible for providing or coordinating Pre-Hospital Emergency Triage and Treatment (PETT) in the Puget Sound Region of Washington State. For the purposes of this annex, the Puget Sound Region (see figure 1-1) is defined as the Seattle Urban Area (UA)/Combined Statistical Area (CSA), and includes the counties of: Island, King, Kitsap, Mason, Pierce, Skagit, Snohomish, Thurston; local jurisdictions and tribal governments located therein; as well as associated public, private, and non-profit businesses. The Puget Sound Region is located in Region X of the Federal Emergency Management Agency (FEMA).

This annex addresses the overall coordination of field triage, treatment, transportation and disposition of patients inside the Puget Sound Region, from first alarm through the emergency medical and hospital system response.

Puget Sound RCP Region	
State of Washington	
Counties Included	**Principal Cities Included[1]**
Island County	Oak Harbor
King County	Bellevue, Kent, Renton, Seattle
Kitsap County	Bremerton, Silverdale
Mason County	Shelton
Pierce County	Tacoma
Skagit County	Mount Vernon
Snohomish County	Everett
Thurston County	Olympia

Figure 1-1: Designated Region for Catastrophic Coordination

C. Situation

1. Demographics

According to the U.S. Census Bureau, the estimated population in 2009 of the Seattle-Tacoma-Olympia Combined Statistical Area was nearly 4.2 million people. This represents a 13 percent increase in the population size for the CSA since 2000. The City of Seattle has the largest population of any metropolitan area in the Puget Sound Region with approximately 582,454 people, or a population density of 6,717 persons per square mile. The region's other major cities include Bellevue to the east (population of 118,186 and population density of 3,940/sq mile); Tacoma to the south (population of 196,532 and population density of 3,931 persons/sq mile); Everett to the north (population of 98,514 and population density of 3,079 persons/sq mile); and Bremerton to the west (population of 35,295 and population density of 1,604/sq mile).

Table 1-1 provides basic demographic information relevant to the PETT capability for the eight counties within the Puget Sound Region.

Table 1-1 Demographic characteristics for the Puget Sound Region

County	Total population (2009)*	Population density (persons per sq mile)**	Number of hospitals+	Number of licensed beds±	Trauma services
Island	81,054	344	1	50	1 (level 3)
King	1,916,441	817	20	5,037 (65% located in the City of Seattle)	1 (level 1) 1 (ped level 1) 3 (level 3) 4 (level 4) 1 (level 5)
Kitsap	240,862	586	3	297	1 (level 3)
Mason	58,016	51	1	68	1 (level 4)
Pierce	796,836	417	5	1,244	2 (level 2) 1 (level 3) 1 (level 4) 1 (ped level 1)
Skagit	119,534	59	3	68	2 (level 3) 1 (level 4)
Snohomish	694,571	290	4	699	1 (level 3) 3 (level 4) 1 (ped level 3)
Thurston	250,979	285	2	509	1 (level 3) 1 (level 4)

* U.S. Census Bureau. State and County Quickfacts. Available at: http://quickfacts.census.gov/qfd/states/53000.html.
** Based on figures reported in the 2000 U.S. Census.
+ Washington State Hospital Directory, Available at: www.doh.wa.gov/EHSPHL/hospdata/Hdirectory/HospDirWOther.xls; note that these figures do not include DoD or VA facilities, or specialty hospitals (e.g., psychiatric facilities).
± Washington State Hospital Directory, Available at: www.doh.wa.gov/EHSPHL/hospdata/Hdirectory/HospDirWOther.xls

2. Hazards

Washington State's Hazard Identification and Vulnerability Assessment (HIVA, April 2009) and local Comprehensive Emergency Management Plans identify the technological and natural hazards that are present and pose a threat to the people, property, environment, and economy of Washington State and the Puget Sound Region. The Puget Sound Region faces a diverse range of hazards that could develop into catastrophic incidents. Relevant risks to the region include natural disasters (e.g., earthquakes, volcano eruptions, floods, landslides, wildfires, tsunami, and severe storms/weather events); biological incidents (e.g., pandemic influenza, bioterrorism); large-scale accidental or intentional explosions, possibly with chemical or radiological components (e.g., manufacturing/storage/transportation accidents or terrorist related explosive devices); and technological (human caused) hazards.

D. Planning Assumptions

General planning assumptions for the coordination of the regional response to a catastrophic incident are outlined in the *Puget Sound Regional Catastrophic Disaster Coordination Plan* and are applicable to this annex as well. The following planning assumptions are specific to the pre-hospital response to a catastrophic incident.

- The initial pre-hospital response to a catastrophe will rely almost exclusively on local jurisdictional assets in the affected region(s). State or Federal resources may not be available during the first 48-72 hours of response.
- An EMS Coordination Group will convene, *only as necessary*, to develop regional situational awareness and provide strategic and policy-level coordination for the pre-hospital response, without impacting local protocols or plans for tactical response.
- During a catastrophic incident, competing demands may require resource prioritization and rationing. The EMS Coordination Group will develop consensus-based recommendations regarding the prioritization of pre-hospital response requirements in the region. The EMS Coordination Group will use the processes outlined in this annex to develop its recommendations.
- Weapons of Mass Destruction (WMD) Field Protocols and/or existing State Medical Program Director Protocols are State protocols that establish the standard for field performance in a Mass Casualty Incident (MCI). WMD Field Protocols are available at: http://www.doh.wa.gov/hsqa/emstrauma/download/allhazprot.pdf.
- A local EMS authority and/or the Incident Commander may establish one or more Field Treatment Sites (FTS) to serve as temporary holding areas for patients until they can be transported to a hospital or other appropriate health care facility. The FTS may be used for patient assembly, triage (sorting), and provision of initial, life-saving medical treatment. An FTS is considered part of the pre-hospital response system; it is not part of the health care system's response to augment medical surge capacity. An FTS is generally not pre-identified but may be established in strategic locations near the disaster area.
- Local Health Officers may implement Alternate Care Facilities (ACF) to augment the medical surge capacity of the region's health care system. An ACF is differentiated from an FTS in that it provides for the long-term holding and treatment of non-acute patients in order to increase the available bed capacity within the health care system for more critically ill or injured patients. An ACF is usually pre-identified within a jurisdiction.
- In a catastrophe, the volume of patients requiring medical treatment will likely overwhelm the surge capacity of hospitals and other health care facilities in the Puget Sound Region. Patients will need to be evacuated outside of the Puget Sound Region for care under the *Regional Medical Evacuation and Patient Tracking Mutual Aid Plan (MAP).*
- Detailed tracking and patient identification during a catastrophic incident will be initiated at the hospital or point of definitive care. Field triage includes an ongoing

assessment of the severity of injuries, estimated/total numbers of injuries, and patient disposition.

- During a catastrophic incident, one hospital may be designated to serve as the Disaster Medical Control Center (DMCC) for the Puget Sound Region. This function (which is also referred to as Hospital Control) provides EMS with a coordinated and planned distribution of patients to area hospitals or other health care facilities based on patient needs (clinical management) and concurrent assessment of hospital capabilities during the distribution. For the purposes of this annex, the terms DMCC and Hospital Control are synonymous.

  Harborview Medical Center (HMC), the only Level 1 Trauma Center in Washington State, will assume primary responsibility for the regional DMCC function during a catastrophic incident. In the event HMC is not able to serve as the DMCC, a backup facility will be chosen from the following candidates:

  - Providence Regional Medical Center, Everett (North boundary)
  - MultiCare Good Samaritan Hospital, Puyallup (South boundary)

- In a catastrophe, the Governor of Washington State will request Federal assistance under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act. A resulting Presidential declaration of emergency or major disaster may trigger the activation of the National Disaster Medical System (NDMS) subsequent to a State request for medical assistance. Absent a Stafford Act declaration, the Secretary of the U.S. Department of Health and Human Services (HHS) may request activation of the NDMS in a declared Public Health Emergency.

- Under Presidential disaster and Public Health Emergency declarations, the Secretary of HHS may implement temporary waivers of certain Medicare, Medicaid, and Children's Health Insurance Program requirements under section 1135 of the Social Security Act. This includes waiver of Emergency Medical Treatment and Labor Act (EMTALA) sanctions for direction or relocation of an individual to receive a medical screening examination in an alternative location pursuant to an appropriate State emergency preparedness plan, or transfer of an individual who has not been stabilized if the transfer is necessitated by the circumstances of the declared emergency.

- A long-term care facility evacuation plan for King and Pierce Counties has been developed under the Regional Catastrophic Preparedness Grant Program concurrent with the Pre-Hospital Emergency Triage and Treatment Annex. The long-term care facility evacuation plan includes mutual aid agreements for resource sharing and does not rely principally on EMS resources to transport individuals to receiving facilities. Similar plans in other counties across the Puget Sound Region are not yet developed (as of Jan, 2011).

II. SYSTEM DESCRIPTION FOR PRE-HOSPITAL COORDINATION

This section describes the purpose and composition of the EMS Coordination Group, as well as the roles and responsibilities of this group during the response to catastrophic incidents.

A. EMS Coordination Group Overview

1. Role of the EMS Coordination Group

The EMS Coordination Group provides senior leadership and strategic coordination to the pre-hospital planning and response to actual or potential catastrophic incidents affecting the Puget Sound Region. *It is important to emphasize that the EMS Coordination Group does not become involved in tactical response decisions. These decisions will be made by responsible officials at the jurisdictional level under their existing authorities, policies, plans, and procedures.*

A primary role of the EMS Coordination Group is to gather situational assessment information from jurisdictions in order to develop situational awareness of the region's pre-hospital response needs. Any one or more of the following sources may be used to obtain situational assessment information for the pre-hospital response:

- City, County and State Emergency Operations Centers (EOCs)
- Regional DMCC
- Medical Program Directors
- EMS Coordination Group Representatives
- News media, radio, Internet, etc.

In addition, the EMS Coordination Group may develop recommendations on strategic or policy-level issues related to the region's pre-hospital response. Such issues may include, but are not limited to, the following:

- Prioritization of pre-hospital response requirements when the region's pre-hospital response system is severely strained or overwhelmed. The following criteria will be used as the basis for developing recommendations related to prioritization of pre-hospital response needs for the region:
  - Life Safety
    - Responders
    - Public
  - Incident stabilization
  - Property conservation
  - Environmental impact
- Establishment and operation of Field Treatment Sites

- Distribution of patients within the regional health care system based on patient need(s) and a concurrent assessment of hospital capabilities during incident response
- Implementation of State protocols establishing the standard for field performance in a catastrophic incident.

Because the EMS Coordination Group has no decision-making authority, its recommendations are intended only to provide decision makers with the information that they need to understand the region's pre-hospital response needs so they can make informed decisions. Therefore, EMS Coordination Group recommendations are disseminated, in print and/or electronic format, to the following entities:

- Emergency Support Function (ESF) 4 (Firefighting) and ESF 8 (Public Health and Medical) representatives at the respective County Emergency Operations Centers (EOCs) and the Washington State EOC (ESF 8 only)
- County/City Fire Chiefs
- Regional and local DMCCs
- County/City Medical Program Directors
- County/City Public Health Officers
- Other multi-agency coordination groups that either have a role in supporting the pre-hospital response or may be impacted by the pre-hospital response
- Other entities, as deemed appropriate by the EMS Coordination Group

2. Composition of the EMS Coordination Group

The EMS Coordination Group consists of a core membership that convenes virtually (typically via a conference call) whenever this annex is implemented. Core members are responsible for helping to develop regional situational awareness and consensus-based recommendations, when necessary, on strategic or policy issues related to the pre-hospital response. The core membership consists of:

- County Fire Chiefs' Representative (counties may default to county ESF 4)
- Regional DMCC Representative (Harborview Medical Center) and back-up DMCCs (Multicare Good Samaratin Hospital and Providence Everett Medical Center)
- County Public Health Officer (counties may default to county ESF 8)
- Medical Program Directors (eight counties and City of Seattle)
- Washington State ESF 8 representative

EMS Coordination Group representatives should be senior-level administrators or officials who are authorized to represent the interests of, and speak on behalf of, their constituency in EMS Coordination Group deliberations. One representative may represent a group of agencies or organizations on the EMS Coordination Group (e.g., one County Medical Program Director may represent four counties) through a Memorandum of Agreement (MOA). In addition, each core member must identify and train two backup representatives to assist the primary representative

or represent him/her in EMS Coordination Group deliberations if the primary representative is unavailable.

The EMS Coordination Group has the flexibility to call on a variety of subject matter experts (SMEs) during response to provide guidance, on an as-needed basis, depending on the type of incident and the jurisdictions involved. SME advisors provide advice or guidance only; they do ***not*** have direct input into EMS Coordination Group recommendations. Potential SME advisors include, but are not limited to, the following:

- Washington State Department of Health EMS Liaison
- Washington Ambulance Association representative
- County Coroner(s) or Medical Examiner representatives
- Non-Governmental Organization (NGO) representative(s) (e.g., American Red Cross)
- Healthcare Coalition representative(s)
- Fire and EMS representative(s) from jurisdictions outside the Puget Sound Region
- Others, as deemed appropriate by the core members of the EMS Coordination Group

B. EMS Coordination Group Components and Roles

This section describes the organizational structure (see Figure 2-1) and roles of the EMS Coordination Group and its supporting elements, which include the EMS Coordination Group Coordinator, Situation Assessment Unit, Resource Status Unit, and Documentation Unit.

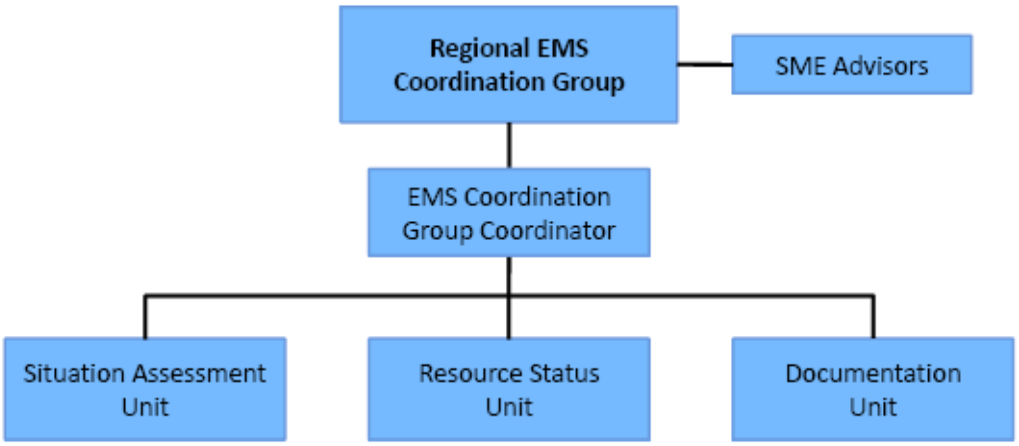

Figure 2-1: EMS Coordination Group Organization Chart

1. Responsibility of EMS Coordination Group Core Membership

As noted previously, the core membership of the EMS Coordination Group participates in virtual meetings during the response to any catastrophic incident that affects the Puget Sound Region.

The meetings are held only as necessary to minimize the burden on the participants, and they typically will occur virtually through a dedicated teleconference and/or web-based system.

Core member representatives on the EMS Coordination Group:

- Provide input on the pre-hospital response needs within their jurisdiction or area of responsibility in order to develop situational awareness of the regional, pre-hospital response. Representatives are also responsible for communicating this regional situational awareness back to their respective Agency Administrators.
- Develop consensus-based recommendations on how to prioritize pre-hospital response needs across the region. Representatives may also collectively develop recommendations on how requests for supplemental pre-hospital assistance should be prioritized through established State procedures.
- Develop consensus-based strategic or policy recommendations for the pre-hospital response, including guidance on how to address or resolve conflicting policies among agencies or jurisdictions. Representatives are also responsible for communicating the EMS Coordination Group's recommendations back to their respective Agency Administrator.
- Coordinate the implementation of Washington State protocols (alternate standards of care, WMD Field Protocols, etc.) that establish the standard for field performance during a catastrophe in consultation with EMS County Medical Program Directors.
- Support the Regional DMCC in promulgating a strategy for the efficient distribution of patients to area hospitals based on patient needs and a concurrent assessment of hospital capabilities during incident response.
- Attend functional meetings annually for trainings/exercises, to review this annex, develop policies and procedures, and maintain up-to-date membership.

2. EMS Coordination Group Chairperson

The EMS Coordination Group will elect a Chairperson to moderate discussion among the core representatives. The Chairperson is responsible for encouraging full participation among EMS Coordination Group members by ensuring a fair and transparent process for providing input and developing recommendations. The Chairperson may also represent the interests of the EMS Coordination Group to other functional area leaders within the Puget Sound Region or to other coordination groups (e.g., Regional Multi-Agency Coordination Group) when planning for, responding to, or recovering from a catastrophic incident.

The initial Chairperson shall be the King County Medical Program Director. The Chairperson shall rotate every two years among the EMS Coordination Group's core membership through open nominations with a majority vote. Nominees must be from counties other than the incumbent's county.

3. EMS Coordination Group Coordinator

In order for the EMS Coordination Group to function effectively and efficiently during incident response, an administrative support structure must be in place. This support structure is led by the EMS Coordination Group Coordinator, who has the following responsibilities:

- Maintain the EMS Coordination Group's core membership list, including up-to-date and redundant emergency contact information for representatives and their backups.
- Establish and disseminate EMS Coordination Group meeting/conference call schedules and agendas to core member representatives.
- Invites SME advisors to participate in EMS Coordination Group deliberations at the request of the core membership.
- Develop and display all needed schedules, tables, data sheets or other information, and ensure EMS Coordination Group feedback on all documents.
- Provide a brief update at the start of each meeting regarding any new developments since the previous EMS Coordination Group meeting, and an account of key issues to discuss during the meeting (as reflected in the agenda).
- Oversee the Situation Assessment Unit, Resource Status Unit, and Documentation Unit to ensure pertinent information is collected, collated, and disseminated to EMS Coordination Group core members and other relevant parties. Depending on the size and complexity of an incident, and staff availability, the EMS Coordination Group Coordinator may also support/fulfill the functions performed by one or more of these units during incident response.
- Ensure adequate equipment and supplies are available and operational for EMS Coordination Group meetings and functions, including dedicated, redundant telecommunications systems, web-based applications/tools, and accessible information technology (IT) support.
- Assist in planning and developing annual EMS Coordination Group trainings and exercises.

This position will be held by the Central Region EMS and Trauma Council – Pre-Hospital Sub-Committee Chairperson until such time as the Puget Sound Regional Catastrophic Disaster Coordination Plan sustainment program is implemented.

4. Situation Assessment Unit

The Situation Assessment Unit collects and collates pertinent information on the incident (e.g., activation status of county/state EOCs, transportation issues, weather conditions), as well as the pre-hospital response from affected jurisdictions and agencies to provide regional situational awareness. This support unit also gathers information from the Resource Status Unit on critical resource needs and the availability of resource caches in the region. The following sources may be used to gather relevant information:

- County EOCs and Washington State EOC
- Regional and local DMCCs

- EMS Coordination Group representatives
- Medical Program Directors
- County Public Health Officers
- News media, radio, Internet, etc.

Depending on the size and complexity of an incident, the Situation Assessment function may be filled by the EMS Coordination Group Coordinator or another person that can assist the Coordinator in providing this support. This position will be held by the Central Region EMS and Trauma Council – Pre-Hospital Sub-Committee Chairperson until such time as the *Puget Sound Regional Catastrophic Disaster Coordination Plan* sustainment program is implemented.

5. Resource Status Unit

The primary role of the Resource Status Unit is to track pre-hospital resource needs (requests) and availabilities of pre-hospital equipment and personnel throughout the incident. Specifically, this function entails:

- Obtaining input from County EOCs on critical pre-hospital resource needs (e.g., mass casualty caches/trailers, Personal Protective Equipment (PPE), and Metropolitan Medical Response System (MMRS) antidote stockpiles)
- Maintaining a database of resource cache availability in the region and assisting the EMS Coordination Group Coordinator in developing displays to facilitate EMS Coordination Group deliberations (*see Appendix B for a summary of existing Pre-Hospital Emergency Triage and Treatment caches in the region)*.
- Providing resource status updates to the Situation Assessment Unit, as requested, to assist in providing situational awareness for the regional pre-hospital response.

6. Documentation Unit

The Documentation Unit maintains a written record of all EMS Coordination Group proceedings and archives this information so that it is easily accessible and can be used to inform After Action Reviews or the development of trainings/exercises. The following types of information may be recorded and maintained by the Documentation Unit:

- Attendance and notes taken from all EMS Coordination Group meetings/conference calls
- Situational awareness for the regional pre-hospital response
- EMS Coordination Group recommendations and the criteria used by the EMS Coordination Group to develop its recommendations

The Documentation Unit is responsible for disseminating any recommendations developed by the EMS Coordination Group to County EOCs and the Washington State EOC (through the respective ESF 4 and ESF 8 representatives in the EOCs), and other relevant groups in the region via email, print, conference call, Web sites, etc. In addition, the Documentation Unit

prints and archives any recommendations on EMS Coordination Group letterhead, signed and dated by the EMS Coordination Group Chairperson.

C. Meeting Format and Decision-Making Process

1. EMS Coordination Group Meeting Format

The EMS Coordination Group typically meets virtually during a catastrophic incident through the use of secure web-conferencing or teleconferencing capabilities. The EMS Coordination Group Coordinator tightly facilitates the meetings using a pre-established agenda in order to limit time commitments and keep the focus on strategic or policy issues relevant to the pre-hospital response.

The EMS Coordination Group Coordinator will begin each meeting by conducting a roll call and providing situational awareness for the regional pre-hospital response. Potential issues to address include an assessment of the pre-hospital system for incident and non-incident related demands, resource needs, projected reduction of available EMS staff and other pre-hospital response capability (e.g., equipment and supplies). The EMS Coordination Group Coordinator will also brief any new developments since the previous meeting and review previous recommendations from the EMS Coordination Group.

The EMS Coordination Group Chairperson will moderate discussion on strategic or policy-level issues that require EMS Coordination Group input (see Appendix C). The following discussion format is followed during the meeting (see Appendix E for an example template):

- The EMS Coordination Group Chairperson introduces an issue/problem
- Representatives and SME advisors discuss the specific issue/problem and its implications for the regional pre-hospital response, and identify options or potential solutions
- The EMS Coordination Group Chairperson, in collaboration with the representatives, develops a consensus-based recommendation for the issue/problem.

The EMS Coordination Group Coordinator schedules the next meeting before the group adjourns. The EMS Coordination Group Coordinator forwards notes from the meeting, including any recommendations that the group develops, to the Documentation Unit to be archived and disseminated to relevant County/State agencies or other organizations.

2. Decision-Making Process

Only core members of the EMS Coordination Group may develop recommendations for the pre-hospital response. All issues brought before the EMS Coordination Group will be acted upon by *consensus* and result in one of the following actions:

- **Option 1:** Make a collaborative recommendation and assign responsibility and expectation for implementation
- **Option 2:** Defer the decision for consideration at a later date (e.g., until more information has been collected)

- **Option 3:** Defer decisions that are beyond the scope of the EMS Coordination Group to the appropriate authorities.

D. EMS Coordination Group IT/Telecommunications

Communications and information technology (IT) systems, to include teleconferencing or web-based conferencing capability, must be available 24/7 for use by the EMS Coordination Group. The Pierce County Everbridge emergency notification system will be utilized as the primary system to support teleconferencing capability for the EMS Coordination Group during incident response (see Implementation Triggers and Protocols for further information on how regional conference calls will be initiated). In the event the Everbridge system is unavailable, Kitsap or Snohomish County Department of Emergency Management will provide a dedicated teleconference line for use by the EMS Coordination Group.

The EMS Coordination Group maintains communications links through the following: VHF, UHF, 700/800; and Telephone, VOIP. The EMS Coordination Group maintains IT infrastructure (with 24/7 technical support) through the following: computer networking; Polycom or similar; Webcast/WebEOC; and display capability.

Protocols for the use of communications technology should be defined during preparedness planning and shared with representatives on the EMS Coordination Group.

III. CONCEPT OF COORDINATION

This section describes the authorities and triggers for implementing this annex in a catastrophe. It describes the various implementation phases and the role of the EMS Coordination Group during each phase. This section also describes how the EMS Coordination Group coordinates with and disseminates its recommendations to jurisdictional officials that have authority and responsibility for emergency response.

A. Authority for Annex Implementation

Any core member of the EMS Coordination Group, as well as County Emergency Managers, County or City Fire Chiefs, or a County Executive or City Mayor (or his/her designee) within the Puget Sound Region may request the implementation of this annex.

B. Implementation Triggers and Protocol

Triggers that could require implementation of this annex include, but are not limited to, any one or more of the following conditions:

- A potential or imminent threat of a catastrophic incident
- Implementation of more than one county's, city's and/or tribe's Mass Casualty Incident (MCI) plan
- Declaration of emergency by at least one local jurisdiction or tribal authority
- Governor-declared State of Emergency
- Request/initiation of Regional Hospital Control for patient distribution
- Implementation of local and/or State Public Health and medical emergency response plans
- Determination by EMS officials that information sharing and strategic or policy level coordination is needed
- Any incident that has a catastrophic impact on critical infrastructure, including communications and transportation systems within the region.

If any one or more of these triggers is met, or in the presence of another indicator of an actual or impending catastrophic incident, any core member of the EMS Coordination Group, or other authority as specified in Section A above, may take the following steps to initiate a regional conference call for the EMS Coordination Group:

- Contact the Pierce County Department of Emergency Management (DEM) by calling **253-798-7470** and requesting notification to all core members of the EMS Coordination Group of the time and instructions (access phone number and passcode, if necessary) for a regional conference call to discuss the regional implications for the pre-hospital response to the incident and any relevant strategic or policy issues

- If Pierce County DEM cannot provide the requested notification, contact either Kitsap or Snohomish County DEM to provide the notification
- If telephone and internet connections are unavailable, the EMS Coordination Group Coordinator, or any core member of the EMS Coordination Group in the Coordinator's absence, may initiate the regional call on amateur radio through county EOCs.

Participants on the first EMS Coordination Group regional call may include all core members of the EMS Coordination Group, as well as the EMS Coordination Group Coordinator and support staff (Situational Assessment Unit, Resource Status Unit, Documentation Unit), as needed.

C. Tiered Incident Levels for Annex Implementation and EMS Coordination Group Response

Implementation of this annex is designed to be flexible in response to changes in the size, scope, or complexity of a disaster threat or actual incident. Consequently, the implementation levels of the EMS Coordination Group, and corresponding actions items, are aligned with the five levels of incident complexity, or "incident levels" used in local emergency planning within the Puget Sound Region.

Thus, the incident levels for the EMS Coordination Group build upon one another, such that the EMS Coordination Group activities defined for one level carry over as the EMS Coordination Group transitions to the next highest level. Activities conducted for purposes of routine plan maintenance or responder education, training, and exercising are noted under Incident Levels 5 and 4 in Table 3-1 below.

The following table provides the scope of EMS Coordination Group response actions, based on the five incident levels.

Table 3-1: EMS Coordination Group Action Items

Incident Level & Operational Impact	EMS Coordination Group Action Items
Levels 5 & 4 Impact Levels: **"Normal" or "Low"** *Daily Pre-Hospital Operations. Routine emergency situations in which EMS requirements are addressed through local resources*	The EMS Coordination Group Coordinator conducts the following activities to maintain the structure and capabilities of the EMS Coordination Group: • Develops and maintains the EMS Coordination Group membership list and contact information • Documents MCI resource caches that exist in the region and identifies potential gaps • Identifies and conducts annual tests of the primary and backup communications systems used by the EMS Coordination Group • Develops and conducts annual trainings and exercises for the EMS Coordination Group, documents lesson learned, and implements corrective actions as needed.

Level 3 Impact Level: **"Moderate"** *An emergency situation or threat that poses a potential catastrophic risk to the region (e.g., major storm risk or a large, pre-planned event)*	The EMS Coordination Group Coordinator conducts the following activities: • Notifies EMS Coordination Group core members to be on standby in the event the situation changes and requires that the EMS Coordination Group convenes • Notifies relevant planning partners for situational awareness of pre-hospital resources • Notifies Situation Assessment Unit, Resource Status Unit, and Documentation Unit leads to be on standby or to collect and/or disseminate information, as needed • Tests the EMS Coordination Group primary and backup communications systems • Updates status of regional MCI caches • Reviews/updates information reporting templates to ensure relevant situation data can be collected for the specific hazard • Gathers information on the incident or threat (through the Situation Assessment Unit) and disseminates a regional situational assessment to EMS Coordination Group core members, as needed • Verifies that the Regional DMCC is activated.
Level 2 Impact Level: "**High**" *An emergency situation that poses a probable or imminent catastrophic threat to the region, or an emergency situation that requires regional coordination but may not be catastrophic.*	The EMS Coordination Group is activated (supported by the Situation Assessment Unit, Resource Status Unit, and Documentation Unit, as needed) and conducts the following activities: • Convenes via conference call (or other available communications mechanism) to develop situational awareness of EMS response requirements in the Puget Sound Region • Reviews the status of regional MCI caches, discusses/documents local mutual aid and resource sharing, and identifies potential resource requests for State, inter-State, or Federal assistance, if applicable • Develops and disseminates pre-hospital status summaries for the Puget Sound Region and any consensus-based strategic or policy recommendations, if applicable, to relevant

	planning partners (e.g., County and State ESF 4 and ESF 8 representatives).
Level 1 Impact Level: **"Severe"** *The scope of the emergency has expanded to the point that limited or no additional EMS resources are available in the Puget Sound region. State, inter-State, and Federal assistance is required.*	All action items listed in Level 2 are completed, if not already done. In addition, the EMS Coordination Group may do the following: • Develop consensus-based recommendations prioritizing requests for State and Federal pre-hospital assistance. The actual requests for assistance are made in accordance with established State procedures • Discuss strategic or policy issues, such as the potential need to establish FTSs or implement MCI standards of field performance in accordance with State protocols • Gathers information (via State ESF 8 representatives) on the activation of NDMS teams and potential forward movement of patients outside of the Puget Sound Region • Identifies pre-hospital resources in the Puget Sound Region needed to move patients to evacuation airheads, if requested by NDMS.

IV. COORDINATION WITH OTHER INCIDENT MANAGEMENT ENTITIES

Figure 4-1 shows the formal pathway for incident management coordination and support (designated by solid black lines), which flows from local jurisdictions to their respective County Emergency Operations Center (EOC), then to the State EOC, and finally to the Federal Government. The EMS Coordination Group **does not** usurp or infringe upon this coordination structure. Instead, the EMS Coordination Group provides a mechanism for pre-hospital responders to collect and share information in order to develop regional situational awareness and recommendations on strategic or policy-level issues related to the pre-hospital response.

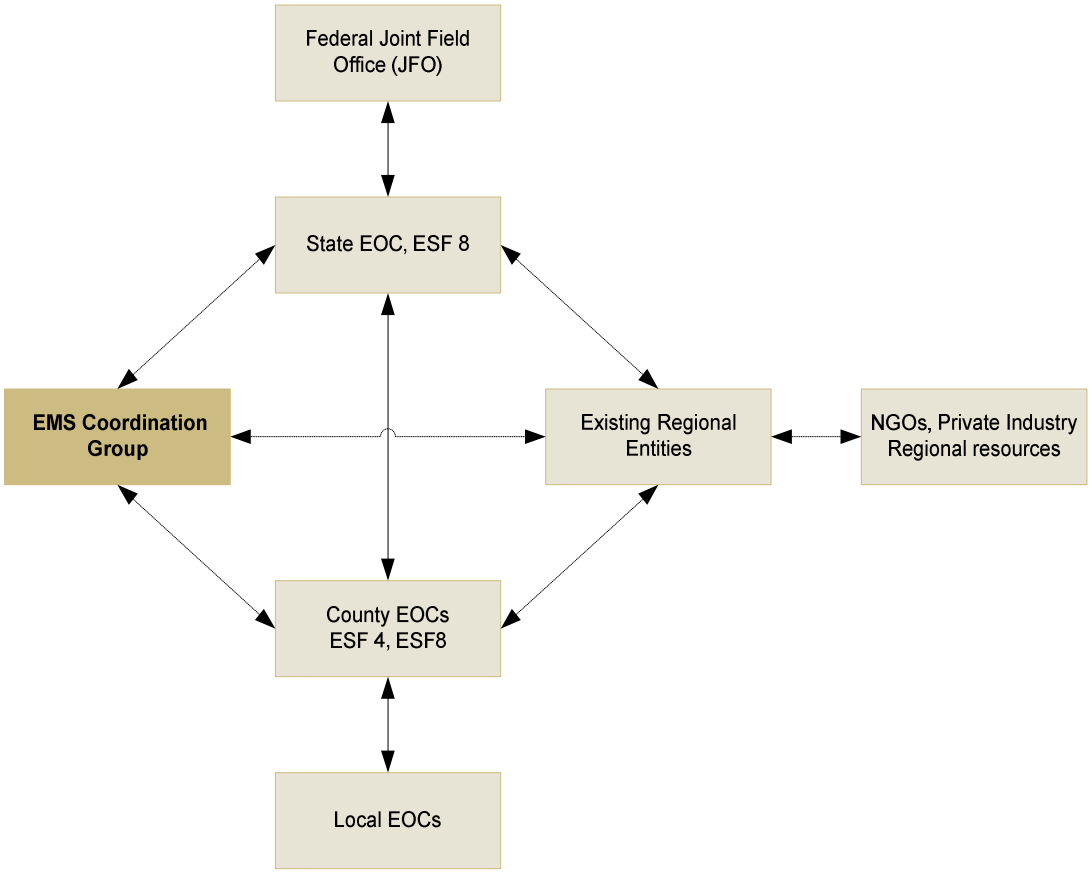

Figure 4-1: Regional EMS Coordination Group Information Flow Diagram

A. Coordination with County/Tribal Governments

During an emergency, county and tribal EOCs are activated to support Incident Command and coordinate the response activities of county/tribal governments, unincorporated areas, and other entities within or adjacent to their jurisdictional boundaries. The EMS Coordination Group facilitates information sharing and multi-jurisdictional pre-hospital response coordination for the Puget Sound Region.

The EMS Coordination Group regularly coordinates with county/tribal government authorities primarily through the County/City Fire Chiefs or County Medical Program Directors who serve as core members of the EMS Coordination Group. During incident response, EMS Coordination Group recommendations are disseminated to the appropriate ESF 4 and ESF 8 representatives at the County EOCs to keep County Emergency Management apprised of the Pre-Hospital Emergency Triage and Treatment response.

B. Coordination with Regional DMCC

The DMCC serves as a conduit for information exchange and common situational awareness between EMS and hospitals during incident response. The DMCC provides EMS with a planned distribution of patients to hospitals and other health care facilities in the region based on patient needs and a concurrent assessment of hospital capabilities.

In a catastrophic incident, the Regional DMCC communicates with the local DMCC, who in turn communicates with local hospitals and health care facilities to obtain status updates. The local DMCC aggregates the data for the Regional DMCC so they can coordinate patient distribution. The Regional DMCC also coordinates with activated NDMS to facilitate patient movement out of the Puget Sound Region, if necessary.

The EMS Coordination Group coordinates with the Regional DMCC via the Regional DMCC representative(s) who serves as a core member of the EMS Coordination Group.

C. Coordination with State Government

The EMS Coordination Group shares information and maintains communications with the State EOC through the State ESF 8 representative that serves on the EMS Coordination Group. The State ESF 8 representative or Washington State Department of Health EMS SME may provide information on the availability of pre-hospital resources to assist the EMS Coordination Group in its deliberations.

D. Coordination with the Federal Government

The EMS Coordination Group coordinates with the Federal Government ***indirectly*** through the State ESF 8 representative who serves as a core member of the EMS Coordination Group. All requests for and receipt of Federal assistance for the pre-hospital response are coordinated through the State EOC or the Federal Joint Field Office (if operational) in accordance with established State protocols.

The EMS Coordination Group *may* help coordinate “on the ground” response operations with deployed NDMS teams for patient movement if so requested by County or State Emergency Management. The EMS Coordination Group may provide strategic guidance on the pre-hospital response as it relates to forward patient movement operations. NDMS and other supplemental teams from outside the region may provide liaisons to the EMS Coordination Group.

V. INFORMATION COLLECTION AND DISSEMINATION

A. Information Reporting Template

The EMS Coordination Group will develop a standardized template to collect information from County ESF 4 and ESF 8 representatives (see Appendix D for a sample template). The reporting template will assist the EMS Coordination Group in developing and maintaining situational awareness of the Pre-Hospital Emergency Triage and Treatment response.

As needed, the ESF 4 and ESF 8 representatives will supply the appropriate information to their respective agencies for dissemination via the Public Information Officer or the Joint Information Center.

VI. ANNEX DEVELOPMENT AND MAINTENANCE

The EMS Coordination Group will annually assess the need for revisions to the Pre-Hospital Emergency Triage and Treatment Annex based on the following considerations:

- Changes to State or Federal regulations, requirements, or organization
- Implementation of tools, procedures or resources (e.g., regional MCI caches) that alter or improve upon annex components
- Lessons learned from EMS Coordination Groups trainings and exercises, or from actual incident response
- The need for additional subsidiary appendices to develop response capabilities or eliminate capability gaps, as suggested by EMS Coordination Group members or developed by the Puget Sound Regional Catastrophic Planning Team (RCPT).

The Regional EMS Coordination Group Coordinator is responsible for the maintenance, revision, and distribution of the Pre-Hospital Emergency Triage and Treatment Annex. The EMS Coordination Group Coordinator will maintain a record of amendments and revisions, as well as executable versions of all documents, and will be responsible for distributing the plan to all applicable agencies.

VII. RECOMMENDATIONS

This section identifies and describes key issues or planning/funding gaps that may affect EMS Coordination Group operations. These issues/gaps require additional work to resolve:

1. Sustainment of staffing for the EMS Coordination Group Coordinator position, as well as the positions in the Situation Assessment Unit, Resource Status Unit, and Documentation Unit.
2. Provision of dedicated and reliable back-up IT/Communications infrastructure needed to support the EMS Coordination Group during incident response.
3. Determining which agency/authority will maintain responsibility for tracking and documenting financial expenditures related to EMS Coordination Group preparedness planning, training/exercising, and response activities.

VIII. AUTHORITIES AND REFERENCES

The *Puget Sound Regional Catastrophic Disaster Coordination Plan* provides generally applicable authorities, requirements, references and regulations for the Regional Coordination Plan, including the Pre-Hospital Emergency Triage and Treatment (PETT) Annex. This section highlights relevant legal authorities and Mutual Aid Agreements that apply to eight-county Puget Sound region, as listed below.

Local

- Seattle Disaster Readiness and Response Plan
- King County Fire Resource Plan
- Pierce County MCI Plan

Regional

- Washington State Region 3 Hospitals Memorandum of Understanding (MOU)
- Washington State Region 7 Healthcare Inter-Jurisdictional Mutual Aid Agreement *(April 2009)*
- Regional Hospital Control Plan
- Regional Medical Evacuation and Patient Tracking Mutual Aid Plan (MAP)
- Pacific Northwest Emergency Management Arrangement (PNEMA)

State

- Washington Administrative Code (WAC)
- Revised Code of Washington (RCW)
- Washington State Emergency Operations Plan (April 2009)
- Washington State Mass Casualty – All-Hazards Field Protocols
- Washington State Fire Services Resource Mobilization Plan
- Cross-Border Ambulance Reciprocity (#05-01), Washington State Department of Health, Office of Emergency Medical Services and Trauma System, Effective November 30, 2003.
- Public Health Mutual Aid Plan Standard Operating Procedures (SOPs) of the Inter-jurisdictional Public Health Mutual Aid Agreement (MAA) *(*January 2009*)*
- Mass Casualty – All Hazards Field Protocol (January 2008)
- Emergency Vaccination Information for EMS Personnel (September 2009, please refer to the active DOH website for the current version and updates)
- Emergency Management Assistance Compact Agreement

Federal

- FEMA National Incident Management System (December 2008)

- Robert T. Stafford Disaster Relief and Emergency Assistance Act (the Stafford Act), 42 U.S.C. §5121-5206
- Homeland Security Presidential Directive 5, Domestic Incident Management (February 28, 2005)
- Homeland Security Presidential Directive 8, National Preparedness (December 17, 2003)
- National Response Framework (March 22, 2008), including the Catastrophic Incident Annex and the Catastrophic Incident Supplement
- DHS National Planning and Execution System (draft March 27, 2007)

Appendix A: Annex Glossary

All-Hazards: Describing an incident, natural or manmade, that warrants action to protect life, property, environment, and public health or safety, and to minimize disruptions of government, social, or economic activities.

Cache: A predetermined complement of tools, equipment, and/or supplies stored in a designated location, available for incident use.

Catastrophic Incident: Any natural or manmade incident, including terrorism, which results in extraordinary levels of mass casualties, damage, or disruption severely affecting the population, infrastructure, environment, economy, national morale, and/or government functions.

Chain of Command: A series of command, control, executive, or management positions in hierarchical order of authority.

Coordinate: To advance systematically an analysis and exchange of information among principals who have or may have a need to know certain information to carry out specific incident management responsibilities.

Disaster Medical Control Center (DMCC): The hospital responsible for providing EMS with a planned distribution of patients to area hospitals based on patient needs (clinical management) and concurrent assessment of hospital capabilities during the distribution. For the purposes of this plan, Harborview Medical Center is designated as the primary Regional DMCC to coordinate patient distribution across the Puget Sound Region with Providence Regional Medical Center, Everett (North boundary) and MultiCare Good Samaritan, Tacoma (South boundary) designated as backups. *(Synonymous with Hospital Control for the purposes of this annex)*

Emergency Medical Services (EMS): This term refers to medical treatment and care that may be rendered at the scene or any medical emergency or while transporting any patient in an ambulance to an appropriate medical facility, including ambulance transportation between medical facilities. *(RCW 70.168.015)*

Emergency Operations Center (EOC): The physical location at which the coordination of information and resources to support incident management (on-scene operations) activities normally takes place. An EOC may be a temporary facility or may be located in a more central or permanently established facility, perhaps at a higher level of organization within a jurisdiction. EOCs may be organized by major functional disciplines (e.g., fire, law enforcement, and medical services), by jurisdiction (e.g., Federal, State, regional, tribal, city, county), or some combination thereof.

Emergency Support Functions (ESFs): Used by the Federal Government and many State governments as the primary mechanism at the operational level to organize and provide assistance. ESFs align categories of resources and provide strategic objectives for their use. ESFs utilize standardized resource management concepts such as typing, inventorying, and tracking to facilitate the dispatch, deployment, and recovery of resources before, during, and after an incident.

Federal: Of or pertaining to the Federal Government of the United States of America.

Field Treatment Sites (FTS): Typically used as temporary holding areas for patients before they can be transported to a hospital or other definitive care facility. They may be used for patient assembly, triage (sorting), and provision of initial, life-saving medical treatment. FTSs are part of the pre-hospital response system and are not part of hospital systems to augment surge capacity. FTSs are generally not pre-identified but are established in strategic locations near the disaster area.

Fire Chief: Includes the chief officer of a statutorily authorized fire agency, or the fire chief's authorized representative. Also included are the Department of Natural Resources fire control chief, and the Department of Natural Resources regional managers. *(Washington State Fire Services Resource Mobilization Plan)*

Hazard: Something that is potentially dangerous or harmful, often the root cause of an unwanted outcome.

Hospital: This term refers to licensed under Chapter 70.41 RCW, or comparable health care facility operated by the Federal government or located and licensed in another State. *(RCW 70.168.015)*

Incident: An occurrence or event, natural or manmade, which requires a response to protect life or property. Incidents can, for example, include major disasters, emergencies, terrorist attacks, terrorist threats, civil unrest, wildland and urban fires, floods, hazardous materials spills, nuclear accidents, aircraft accidents, earthquakes, hurricanes, tornadoes, tropical storms, tsunamis, war-related disasters, public health and medical emergencies, and other occurrences requiring an emergency response.

Jurisdiction: A range or sphere of authority. Public agencies have jurisdiction at an incident related to their legal responsibilities and authority. Jurisdictional authority at an incident can be political or geographical (e.g., Federal, State, tribal, and local boundary lines) or functional (e.g., law enforcement, public health).

Mass Casualty – All-Hazards Field Protocols: Developed by the Washington State Department of Health, Office of Emergency Medical Services and Trauma System, these field protocols are intended to:

- Provide direction for the use of appropriate emergency medical procedures in an all-hazards environment, to be employed by Washington State Certified EMS personnel while working under the direction of the County Program Medical Director;
- Provide for the standardization of pre-hospital care in Washington State;
- Provide base hospital physicians and nurses with an understanding of what aspects of patient care have been stressed to EMS personnel and what their treatment capabilities may be;
- Provide EMS personnel with a framework for pre-hospital care and an anticipation of supportive orders from Medical Control; and
- Provide the basic framework on which Medical Control can conduct quality improvement programs.

Mass Casualty Incident (MCI): Sometimes called a Multiple Casualty Incident, an MCI is an event resulting from man-made or natural causes which results in illness and/or injuries which

exceed the Emergency Medical Services (EMS) capabilities of a locality, jurisdiction and/or region.

Medical Control: Will be provided by county pre-hospital patient care protocols. "Pre-hospital patient care protocols" means the written procedures adopted by the county Medical Program Director (MPD) which direct the out-of-hospital emergency care of the emergency patient. These procedures shall be based upon the assessment of the patient's medical needs and what treatment will be provided for emergency conditions.

National Disaster Medical System (NDMS): A Federally coordinated system that augments the Nation's medical response capability. The overall purpose of the NDMS is to establish a single, integrated national medical response capability for assisting State and local authorities in dealing with the medical impacts of major peacetime disasters. NDMS, under Emergency Support Function #8 – Public Health and Medical Services, supports Federal agencies in the management and coordination of the Federal medical response to major emergencies and federally declared disasters.

National Response Framework (NRF): Guides how the Nation conducts all-hazards response. The Framework documents the key response principles, roles, and structures that organize national response. It describes how communities, States, the Federal Government, and private-sector and nongovernmental partners apply these principles for a coordinated, effective national response. And it describes special circumstances where the Federal Government exercises a larger role, including incidents where Federal interests are involved and catastrophic incidents where a State would require significant support. It allows first responders, decision-makers, and supporting entities to provide a unified national response.

Patient Care Procedures: The written operating guidelines adopted by the regional emergency medical services and trauma care council, in consultation with the local emergency medical services and trauma care councils, emergency communication centers, and the emergency medical services medical program director, in accordance with statewide minimum standards. The patient care procedures shall identify the level of medical care personnel to be dispatched to an emergency scene, procedures for triage of patients, the level of trauma care facility to first receive the patient, and the name and location of other trauma care facilities to receive the patient should an interfacility transfer be necessary. Procedures on interfacility transfer of patients shall be consistent with the transfer procedures in chapter 70.170 RCW.

Planning and Service Regions: The department shall designate at least eight emergency medical services and trauma care planning and service regions so that all parts of the state are within such an area. These regional designations are to be made on the basis of efficiency of delivery of needed emergency medical services and trauma care. *(RCW 70.168.110)*

Pre-Hospital: Means emergency medical care and transportation rendered to patients prior to hospital admission or during interfacility transfer by licensed ambulance or aid service under chapter 18.73 RCW, by personnel certified to provide emergency medical care under chapters 18.71 and 18.73 RCW or by facilities providing Level V trauma care services as provided for in this chapter. *(RCW 70.168.015)*

Pre-Hospital Patient Care Protocols: The written procedures adopted by the emergency medical services medical program director which direct the out-of-hospital emergency care of the emergency patient, which includes the trauma patient. These procedures shall be based upon the assessment of the patient's medical needs and what treatment will be provided for

emergency conditions. These protocols shall meet or exceed statewide minimum standards developed by the department in rule as authorized in chapter 70.168 RCW.

Pre-Hospital Trauma Care Services: means agencies that are verified to provide pre-hospital trauma care. *(WAC 246-976-010)*

Puget Sound Region: For the purposes of this plan, the Puget Sound region is defined as the Seattle Urban Area (UA)/Combined Statistical Area (CSA), which includes the eight Puget Sound counties (Island, King, Kitsap, Mason, Pierce, Skagit, Snohomish, Thurston) and select major cities located therein.

Regional Catastrophic Agreement: An inter-jurisdictional agreement that is made between governments or organizations, either public or private, to provide aid and assistance during emergency situations where resources of a single jurisdiction or organization are insufficient or inappropriate for the tasks that must be performed to control the situation.

Regional Response Regions: The Washington State homeland security planning and coordination structure is divided into nine (9) regions. These regions mirror the State's public health regions. The regions are made up of one or more counties that include cities, towns, and tribal nations within regional geographical boundaries. This regional configuration was implemented to distribute Federal grant funds, develop emergency responder equipment priority lists, plan and execute training and exercise programs, create regionally based mutual aid plans, and develop volunteer infrastructure to support citizens' involvement in homeland security initiatives. Operations and physical resources are maintained at the local jurisdiction (county, city, and tribal) level, and coordination and planning are facilitated at the regional level.

Situational Assessment (report): Document that contains confirmed or verified information and explicit details (who, what, where, and how) relating to an incident.

Situational Awareness: The ability to identify, process, and comprehend the critical elements of information about an incident.

Stafford Act: The Robert T. Stafford Disaster Relief and Emergency Assistance Act, P.L. 93-288, as amended. This Act describes the programs and processes by which the Federal Government provides disaster and emergency assistance to State and local governments, tribal nations, eligible private nonprofit organizations, and individuals affected by a declared major disaster or emergency. The Stafford Act covers all hazards, including natural disasters and terrorist incidents.

Threat: An indication of possible violence, harm, or danger.

Trauma: A major single or multisystem injury requiring immediate medical or surgical intervention or treatment to prevent death or permanent disability. *(RCW 70.168.015)*

Triage: The sorting of patients in terms of disposition, destination, or priority. Triage of pre-hospital trauma victims requires identifying injury severity so that the appropriate care level can be readily assessed according to patient care guidelines. *(RCW 70.168.015)*

Tribal Government (Tribes): Authorized representatives of Federally Recognized Tribes that are sovereign governments within the United States. Within Washington State, Tribes interface with the State during disasters in a very similar manner as other types of local government with respect to seeking supplemental response and recovery support.

Appendix B: Regional MCI Resource Inventory

This appendix will provide an overview of mobile MCI resource caches for Pre-Hospital Emergency Triage and Treatment across the Puget Sound region. The purpose of this inventory is to better understand what resources exist across the region, where they are located, and under whose authority they are maintained (along with appropriate contact information). The inventory will also aid in identifying resource gaps that may require requests for State or Federal assistance.

- Resource categories may include: hospitals; medical transport; skilled nursing facilities/residential care facilities; local medical response teams; local specialized non-medical response team (Hazmat, etc.); significant providers of medical suppliers and equipment; regional healthcare coalition leads.
- Inventories should be updated annually.

Table 3: Regional MCI Resource Inventory

County	Organization	Available MCI Cache	Cache Content	Cache Ownership, Sustainability & Replenishment	Cache Request & Deployment Procedures	Cache Transportation	Cache Deployment Personnel
Island County	Oak Harbor Fire Department	Two trailer units	Medical equipment to treat 25 patients; includes medical supplies, backboards, oxygen manifold system, START program, generator and lights	Oak Harbor Fire Department owns and maintains the units and the cache is sustainable. Funds are available and an inventory is maintained	Units available under mutual aid agreement with all fire and law enforcement in Island County, Whidbey General Hospital, and the Puget Sound Federal Fire Department at Naval Air Station Whidbey Island	Support vehicles available	On-duty personnel available

	Whidbey General Hospital; South Whidbey Fire & Rescue; Naval Hospital Oak Harbor	Multiple decontaminatio n tents	Multiple decontamination tents; hospitals have limited personnel trained in decontamination procedures	Whidbey General POC: Larry Wall, 360-675-1131 South Whidbey POC: Chief Palmer, 360-321-1533 Naval Hospital POC: Jean Lord, 360-257-9471	Contact POC	Decontamination equipment in trailers at Whidbey General South Whidbey & Naval Hospital status unknown	Unknown
King County	Bellevue Fire Department	Medical Supply Unit -1 (MSU -1)	Tents, heaters, generators and lights Can manage ~80 non-ambulatory patients Emphasis on decontamination support, BLS, limited ALS	Cache maintained by Station 9 Captain with support from EMS Division of Bellevue Fire Department	Can be deployed to any current fire zones in King, Pierce and Snohomish County No other pre-existing agreements, but with BC approval, unit should be available to other areas	Self supported / stand alone	Cross-staffed at a fully paid station, ready for immediate deployment with 2 personnel
	Public Health – Seattle King County	Public Health Preparedness and Healthcare Coalition regional cache	520 beds 3 military grade liquid oxygen system for 200+ patients 20 oxygen distribution kits Over 300,000 masks, respirators, defibrillators, other medical kits and supplies for acute care and inpatient services for up to 500 patients/7 days	Contact Bryan Heartsfield, PHSKC, 206-263-8716 Sustainable but some supplies are perishable Replenished through Federal reimbursement funding or local funding	Mutual aid agreements exist between most Public Health departments. Activation of MOA is coordinated and a request form. Contact Public Health Preparedness section or the Public Health On Call Duty Officer	Contract services provided by Evergreen Moving and Storage	24 hour on-call duty officer available. Internal call tree to authorize, initiate contract and move materials

	Seattle Fire Department (SFD)	MCI Van	Backboards for 100 patients; EMS supplies including ALS and BLS to treat ~100 patients	SFD Station 21	Contact SFD Station 21, available to respond when dispatched	Cargo van with no trailers or attachments	Staffed by on-duty crews
King County (cont.)	Port of Seattle & Zone 3	Seattle Tacoma International Airport (Seatac) Cache managed by the Fire Department MCI van cached at South King Fire & Rescue Station 26 and maintained by Zone 3 cooperative agencies Federally supported light rail cache managed by the Tukwila Fire Department	Seatac Airport and Zone 3 cache contain BLS disaster supplies – boards, straps, wound supplies, etc. Tukwila cache – MCI material but also equipment for Light Rail extrication	Port of Seattle (POS) owns and maintains the airport cache Tukwila is responsible for light rail cache. Zone 3 cache is a cooperative effort, contact South King Fire and Rescue	Airport cache is available county-wide Zone 3 cache is available to all locations within Zone 3 Unknown if light rail cache is deployable outside of Tukwila	Airport cache - 40” van container Zone 3 cache - vehicle cache Light rail cache - trailer	All caches are deployable upon request

Kitsap County	Bainbridge Island Fire Department (BIFD)	BIFD Cache	Inventory for treating trauma injuries Bandages, splints, backboards, blankets, IV supplies, intubation for 15 patients, two 10'x10' pop-up shelters, N95 masks, gloves, mass decontamination equipments and other EMS supplies 2010 Purchasing Program will allow care for 15 red, 20 yellow, and 25 green patients	BIFD owns and maintains MCI Cache BIFD POC: Captain Butch Lundin (blundin@bifd.org) or FF/EMT Jason Livdahl (jlivdahl@bifd.org), 8895 Madison Avenue, Bainbridge Island, WA 98110, 206-842-7686 BIFD fully resupplies the cache	Cache deployable in any jurisdiction when requested pending staff availability Cache dispatch through CENCOM or DEM	Cache trailer at Fire Station 21 with available towing vehicle	Duty personnel or on-call personnel will respond with cache
	South Kitsap Fire Rescue (SKFR)	SKFR Cache	Lights, medical supplies and equipment to set up colored treatment areas No special equipment Treat ~25 patients	SKFR owns and maintains cache; resupplied by department using them	Cache requested through 911 system County-wide mutual aid agreement in place	Cache unit can be moved; no plans in place to move other supplies	Duty career staff to respond upon request
Mason County	Mason County Department of Emergency Management/ Mason County Fire Department 5	See Cache Content	Backboard for 50 patients; oxygen and other accessories for a 5-person MCI	Mason County Fire Department 5	Contact MACECOM	1-ton pickup for MCI trailer	Staff available from Mason County Fire Department 5
	Mason General Hospital (MGH)	See Cache Content	Contact Andrew Bales at MGH	Contact Andrew Bales at MGH	Unknown	Limited transport capability	Unknown

Pierce county	Tacoma Fire Department (TFD)	Mobile patient cache and resupply cache for 100 patients	CBRNE PPE and specialized countermeasure pharmaceuticals for 100 responders Oxygen cache of 50 size "K" with transfilling and manufacturing capability; 200 patient treatment capability	City of Tacoma Fire Department, 901 Fawcett Avenue, Tacoma, WA 98402, 253-591-5705 Cache is sustained with MMRS grant funds, all perishables are rotated or replaced prior to expiration Replenishment plan in place	MMRS cache is mobile and deployable outside of jurisdiction. Request through TFD Dispatch Center or TPCHD Medical Group if activated.	Mobile cache in 36ft trailer with dedicated tow unit. Resupply, PPE and oxygen caches are palletized and can be move by several vehicles in the TFD fleet.	Duty TFD are responsible for moving caches

	Lakewood Fire Department (LFD)	BLS, "Multiple Casualty/disaster Response" trailer. 2000lb payload, 7-pin electrical, 2-5/16" two ball (provided) trailer	See "MCI Electronic Inventory", approximately 200 patients treatment capability	Lakewood Fire District 2, 10928 Pacific Highway SW, Lakewood, WA 98499 Rick Jankowiak Office 253-983-4571; Cell: 253-377-3508; Fax: 253-588-2317 Maintained and serviced by Lakewood Fire Department EMS Division No provisions or arrangements for replenishing stock or durable items if utilized, lost or broken Maintenance and resupply will be provided by LFD EMS Division through General Operations Budget Resupply requirements have not been arranged. Expect that utilizing agencies will provide adequate resources to restock MCI capability	Contact Lakewood Fire On-Duty Battalion Chief: 253-582-4600 (non-emergency); or through Pierce County Lakewood FireComm: 253-983-4563 or 911 during emergencies Trailer can be utilized outside of Pierce County by special request or Washington State mobilization requirements/plan	LFD has capability to tow the trailer for local use. LFD has limited capability to deliver to any outside requesting agency. Without special arrangements or direct coordination with the On-Duty Battalion Chief, requesting agencies should provide towing capable vehicle and driver	On-duty personnel will be assigned as necessary to respond to emergency scenes

	Gig Harbor Fire Department – MCI 51	Gig Harbor Fire & Medic One – 50 Patient MCI Trailer at Station 51	Spine boards, bandage supplies, tarps, lights, generator, wheel carts for stretcher, etc. Medical PPE – BLS Supplies for up to 50 patients No CBRNE capability	Gig Harbor FD, 10222 Bujacich Road, NW, Gig Harbor, WA 98332, 253-851-3111 Gig Harbor Fire & Medic One owns and has budget for replacement of used supplies PRN. BLS supplies – very few are perishable	Request through FireComm Dispatched as needed or requested B51 will deploy Can be deployed anywhere in Pierce County through county wide mutual aid agreement	Tow vehicle available	On-duty staff will be assigned by B51 to respond with trailer when requested
Skagit County	Skagit County EMS	5 MCI trailers	Generic mass casualty supplies and PPE but no CBRNE capability	Skagit County EMS owns and maintains MCI trailers with the help of the host fire agency that houses them Replenished as needed	Cache could be used as needed in a mutual aid scenario if needed – in conjunction with 911 dispatch, Department of Emergency Management, and Skagit EMS approval	All host fire departments have the capability to haul MCI trailers	Only Mount Vernon FD, Burlington FD and Sedro-Woolly FD have this capability for personnel 24/7
Snohomish County	City of Everett Fire Department	City of Everett – MCI trailer Paine Field – MCI bus	50 backboards with supplies for 50 patients	Cache is part of the Everett Fire Department Restocked as budget item Maintained with monthly inventory check	Call dispatch – SnoPac and request MCI vehicles Special request through dispatch Call on-duty Battalion Chief and request equipment as needed; or Addressed as a Zone Response in the form of a Strike Team or Task Force	Vehicle available	On-duty personnel can deploy with trailer

Thurston County	Thurston County Fire Department	2 MCI trailers: 1 in Tumwater & 1 in East Olympia	Backboards (40), oxygen manifolds, basic BLS and ALS equipment for up to 60 patients, assuming 1/3 "Green" patients No special equipment	Tumwater Fire Department, Lt. Gary Burkhardt, gburkhardt@ci.tumwater.wa.us Thurston County Fire Department #6, A/C Mark Nelson, mnelson@eofd.org Thurston County Medic One will replenish supplies For out of county response, expect reimbursement or the ability to file a claim for incident-related damage to equipment	TFD trailer dispatched on second alarm MCI in Thurston County FD #6 trailer dispatched on third alarm MCI in Thurston County Deployment to other locations by request – would require agreements (i.e. Mobe agreement) Contact Capcom at 360-704-2749 for out of county response	Cache is contained in a trailers	On-duty personnel can deploy with trailers
Grays Harbor County	Aberdeen Fire Department (AFD)	MCI trailer stored at City of Aberdeen public works motor pool	42 backboards, MCI triage tags, tarps, oxygen manifolds, splinting & bandage supplies, mass decontamination shelters (for ambulatory and non-ambulatory victims)	Aberdeen Fire Department and available on mutual aid request. Nothing perishable	GH County mutual aid agreements in place	AFD Command Unit or heavy duty tow vehicle (standard hitch) available	No one assigned For Deployment within city of Aberdeen, on-duty or call-back Aberdeen Fire Department personnel would deploy For outside response area, call back personnel would deploy

Pacific County	Raymond Fire Department	1 MCI trailer	Basic BLS equipment, backboards, collars, bandages, oxygen manifold for up to 30 patients	Raymond Fire Department Initial timeline supplied by Homeland Security Region 3 No agreement with Region 3 to sustain supplies	Available to any agency in Homeland Security Region 3, although no written agreement in place	Cache contained in trailer	May be deployed outside of agency by on-duty personnel, depending on staffing levels. Likely need to call in personnel

Appendix C: Example Strategic or Policy-Level Issues for EMS Coordination Group Discussion

The following are examples of potential strategic or policy-level issues that may be appropriate for consideration by the EMS Coordination Group during incident response. This list is not meant to be comprehensive and may be modified as more information is gained through EMS Coordination Group trainings or exercises.

- Providing regional situational awareness for the pre-hospital response
- Developing recommendations for pre-hospital response priorities when multiple incidents are occurring across jurisdictions within the region
- Establishment and operation of Field Treatment Sites during incident response
- Guidance on Personal Protective Equipment (PPE) for pre-hospital responders
- Implementation of WMD Field Protocols or alternate standards of care.

Appendix D: Sample Essential Elements of Information (EEI) Template for EMS Coordination Group Situational Assessment

This appendix provides a sample reporting template that may be used during incident response to collect EEI needed by the EMS Coordination Group to provide situational awareness of the pre-hospital response. The template represents a modified version of a reporting template developed for the Bay Area Regional Coordination Plan.

Essential Elements of Information	Specific Information
1. Status of declarations	
2. Boundaries of disaster area	
3. Access points to disaster area	
4. Jurisdictional boundaries	
5. Population/community support impacts	
6. Priorities for pre-hospital response	
7. Projected pre-hospital resource shortfalls	
8. Status of key EMS personnel	
9. Status of ESF activations	
10. Status of critical infrastructure (e.g., transportation, communications)	
11. Status of County EOC activation	
12. Demographics	Population of Impacted Area(s)
13. Weather	
14. Hazard Specific Information	

Appendix E: EMS Coordination Group Conference Call Template

[Date & Time]

Agenda Item	Responsibility
1. Roll Call: EMS Coordination Group core membership	EMS Coordination Group Coordinator
2. Roll Call: SME advisors	EMS Coordination Group Coordinator
3. Situation Assessment update of the regional pre-hospital response	EMS Coordination Group Coordinator
4. Report on Critical Resources	EMS Coordination Group Coordinator [bulleted statements related to the flow/availability of pre-hospital resources within the region]
5. Review current recommendations for regional pre-hospital response priorities	EMS Coordination Group Chairperson
6. Issue identification/discussion	EMS Coordination Group Chairperson/Core Members/ SME advisors [brief description of issue, potential impact, and options/solutions]
7. EMS Coordination Group recommendations	EMS Coordination Group Chairperson
8. Necessary Actions/Follow-up	EMS Coordination Group Coordinator
9. Schedule Next Conference Meeting/call	EMS Coordination Group Coordinator

Appendix F: Training for EMS Coordination Group Members

NIMS/ICS trainings include special courses designed for multi-agency coordination participants and staff. The EMS Coordination Group Coordinator and Agency Representative positions should be able to participate in at least one training and one exercise each year. Trainees should be limited to no more than three at any one time and coordinated through the EMS Coordination Group Coordinator.

NOTE: ICS-100 through 400 ***should*** be taken before filling the EMS Coordination Group Agency Representatives and Coordinator positions.

Additionally, the following courses are available to provide background training for EMS Coordination Group positions:

- M-480 – Multi-Agency Groups – Eight-hour course with classroom instruction and exercises for EMS Coordination Group Agency Representatives and Coordinator positions.
- I-401 – Multi-Agency Coordination and MAC Groups – Seven-hour course with classroom instruction and exercises for EMS Coordination Group Agency Representatives and Coordinator positions.
- IS-701 – Multi-Agency Coordination Systems – Online and classroom course and exercises for broad understanding of the NIMS coordination system.
- ICS-700 NIMS
- ICS-800 NRF
- IS-650 (FEM 143): Building Partnerships with Tribal Governments